		FOR BHF USE					

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0027680

Facility Name: Sheridan Health Care Center

Address: 2534 Elim Avenue (Number) Zion (City) 60099 (Zip Code)

County: Lake

Telephone Number: (847) 746-8435 **Fax #** (847) 746-1744

HFS ID Number:

Date of Initial License for Current Owners: 10/10/1982

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Garry S. Chankin, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 7/1/2010

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	87	Skilled (SNF)	67	28,075	1
2		Skilled Pediatric (SNF/PED)			2
3	163	Intermediate (ICF)	163	59,495	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	250	TOTALS	230	87,570	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	284		6,303	6,587	8
9	SNF/PED					9
10	ICF	64,439	3,686	1,099	69,224	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	64,723	3,686	7,402	75,811	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.57%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels, Adult Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/1982

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/1982 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 67 and days of care provided 5,863

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	575,525	86,812	16,828	679,165		679,165		679,165			1
2	Food Purchase		481,258		481,258		481,258	(234)	481,024			2
3	Housekeeping	415,060	63,309		478,369		478,369		478,369			3
4	Laundry	154,841	53,618		208,459		208,459		208,459			4
5	Heat and Other Utilities			275,324	275,324		275,324	(2,515)	272,809			5
6	Maintenance	244,966	74,704	196,671	516,341		516,341	4,261	520,602			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,390,392	759,701	488,823	2,638,916		2,638,916	1,512	2,640,428			8
	B. Health Care and Programs											
9	Medical Director			31,050	31,050		31,050		31,050			9
10	Nursing and Medical Records	3,841,084	252,365	107,113	4,200,562		4,200,562		4,200,562			10
10a	Therapy	197,123	1,725	14,107	212,955		212,955		212,955			10a
11	Activities	195,222	27,934	46,847	270,003		270,003		270,003			11
12	Social Services	214,117		8,728	222,845		222,845		222,845			12
13	CNA Training											13
14	Program Transportation			4,748	4,748		4,748		4,748			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,447,546	282,024	212,593	4,942,163		4,942,163		4,942,163			16
	C. General Administration											
17	Administrative	118,674		64,542	183,216		183,216	(16,989)	166,227			17
18	Directors Fees											18
19	Professional Services			85,388	85,388	(3,500)	81,888	(3,219)	78,669			19
20	Dues, Fees, Subscriptions & Promotions			91,383	91,383		91,383	(48,293)	43,090			20
21	Clerical & General Office Expenses	228,962	7,519	226,292	462,773		462,773	(92,680)	370,093			21
22	Employee Benefits & Payroll Taxes			1,111,039	1,111,039		1,111,039	(3,744)	1,107,295			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,380	14,380		14,380		14,380			24
25	Other Admin. Staff Transportation			1,105	1,105		1,105		1,105			25
26	Insurance-Prop.Liab.Malpractice			251,403	251,403		251,403		251,403			26
27	Other (specify):*							3,146	3,146			27
28	**TOTAL General Administration**	347,636	7,519	1,845,532	2,200,687	(3,500)	2,197,187	(161,780)	2,035,407			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,185,574	1,049,244	2,546,948	9,781,766	(3,500)	9,778,266	(160,267)	9,617,999			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Sheridan Health Care Center #0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			321,759	321,759		321,759	161,177	482,936			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			201,837	201,837		201,837	(2,656)	199,181			32
33	Real Estate Taxes			229,000	229,000	3,500	232,500		232,500			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			22,283	22,283		22,283		22,283			35
36	Other (specify):*			3,950	3,950		3,950	(3,950)				36
37	TOTAL Ownership			778,829	778,829	3,500	782,329	154,571	936,900			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		598,253	573,640	1,171,893		1,171,893		1,171,893			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			131,355	131,355		131,355		131,355			42
43	Other (specify):*	58,577		16,897	75,474		75,474	(75,474)	(0)			43
44	TOTAL Special Cost Centers	58,577	598,253	721,892	1,378,722		1,378,722	(75,474)	1,303,248			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,244,151	1,647,497	4,047,669	11,939,317		11,939,317	(81,170)	11,858,147			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,515)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	161,907	30		9
10	Interest and Other Investment Income	(1,906)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(234)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(13,565)	21		18
19	Entertainment				19
20	Contributions	(2,947)	20		20
21	Owner or Key-Man Insurance	(3,744)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(70,131)	21		24
25	Fund Raising, Advertising and Promotional	(36,513)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(97,680)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (67,327)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(13,843)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (13,843)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (81,170)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Sheridan Health Care Center

ID# 0027680

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (4,632)	21	1
2	Bank Charges	(55)	21	2
3	Marketing Expense	(12,723)	43	3
4	COPE Dues	(8,833)	20	4
5	Non Allowable Interest	(750)	32	5
6	Additional Repairs and Maintenance	11,598	06	6
7	Adult Day Care Cost	(60)	43	7
8	Bank Loan Fees	(3,950)	36	8
9	Non Allowable Professional Fees	(1,904)	19	9
10	Marketing Salaries	(58,577)	43	10
11	Non-Allowable Legal	(1,315)	19	11
12	Prior Period Adjustment	(4,297)	21	12
13	Non-Care Asset Depreciation	(730)	30	13
14	Marketing Travel	(4,114)	43	14
15	Capitalized R & M	(7,337)	06	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(97,680)		49

Sheridan Health Care Center

ID# 0027680

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Sheridan Health Care Center **#** 0027680 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(234)											(234)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(2,515)											(2,515)	5
6	Maintenance	4,261											4,261	6
7	Other (specify):*													7
8	**TOTAL General Services**	1,512											1,512	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative			(21,854)	4,865								(16,989)	17
18	Directors Fees													18
19	Professional Services	(3,219)											(3,219)	19
20	Fees, Subscriptions & Promotions	(48,293)											(48,293)	20
21	Clerical & General Office Expenses	(92,680)											(92,680)	21
22	Employee Benefits & Payroll Taxes	(3,744)											(3,744)	22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*			2,762	384								3,146	27
28	**TOTAL General Administration**	(147,937)		(19,092)	5,249								(161,780)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(146,424)		(19,092)	5,249								(160,267)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Sheridan Health Care Center** **# 0027680** **Report Period Beginning:** **01/01/10** **Ending:** **12/31/10**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	161,177											161,177	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,656)											(2,656)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(3,950)											(3,950)	36
37	**TOTAL Ownership**	154,571											154,571	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(75,474)											(75,474)	43
44	**TOTAL Special Cost Centers**	(75,474)											(75,474)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(67,327)		(19,092)	5,249								(81,170)	45

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY - STAN ARON	$	PRO HEALTH CARE, INC.	100.00%	$ 34,146	$ 34,146	15
16	V	27	PAYROLL TAXES				2,762	2,762	16
17	V								17
18	V	17	MNGMNT. FEES - PRO HEALTH	56,000				(56,000)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 56,000			$ 36,908	$ * (19,092)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY - RON SHABAT	$	SHABAT & ASSOCIATES	100.00%	$ 4,865	$ 4,865	15
16	V	27	PAYROLL TAXES				384	384	16
17	V								17
18	V	17	MANAGEMENT FEES						18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 5,249	$ * 5,249	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stan Aron	Owner	Administrative	22.56%	See Attached	14	25.45%	Alloc. Salary	$ 34,146	17-07	1
2	Ron Shabat	Owner	Administrative	13.21%	See Attached	3	8.57%	Alloc. Mgmt Fee	4,865	17-07	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be allowable										10
11	by the Il. Dept of HFS.										11
12											12
13								TOTAL	$ 39,011		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PRO HEALTH CARE, INC. C/O FR&R
Street Address: 111 PFINGSTEN ROAD
City / State / Zip Code: DEERFIELD, IL 60115
Phone Number: (847)236-1111
Fax Number: (847)236-1155

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY - STAN ARON	AVG. HOURS WORKED	41	4	$ 100,000	$ 100,000	14	$ 34,146	1
2	27	PAYROLL TAXES	AVG. HOURS WORKED	41	4	8,087		14	2,762	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 108,087	$ 100,000		$ 36,908	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SHABAT & ASSOCIATES
Street Address: 7514 N. SKOKIE BLVD.
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: ((847)982-1195
Fax Number: ((847)982-0992

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY - RON SHABAT	AVG. HOURS WORKED	35	9	56,755	56,755	3	4,865	1
2	27	PAYROLL TAXES	AVG. HOURS WORKED	35	9	4,479		3	384	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 61,234	$ 56,755		$ 5,249	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	MB Financial Bank		X	Mortgage			$ 2,439,763	$ 2,088,967			$ 147,620	1
2								37,677				2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	MB Financial Bank		X	Line of Credit	Varies			934,644			52,081	6
7	Bridgeview Bank		X	Line of Credit	Varies						1,386	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$ 2,439,763	$ 3,061,288			$ 201,087	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,906)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (1,906)	14
15	TOTALS (line 9+line14)						$ 2,439,763	$ 3,061,288			$ 199,181	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Shareholder Interest	X					$	$			$ 750	8
9	Non-Allowable Interest	X									(750)	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Sheridan Health Care Center # 0027680 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.	$	219,916	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	224,434	2
3. Under or (over) accrual (line 2 minus line 1).	$	4,518	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	224,482	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**	$	3,500	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	232,500	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	202,078	8
	2006	206,222	9
	2007	202,950	10
	2008	213,512	11
	2009	224,434	12

2010 Accrual = $224,434 x 1.0002 = $224,482

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheridan Health Care Center COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0027680

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-22-301-007	Long Term Care Property	$ 208,035.87	$ 208,035.87
2.	04-22-301-009	Long Term Care Property	$ 16,398.26	$ 16,398.26
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 224,434.13	$ 224,434.13

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheridan Health Care Center COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0027680

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original second installment tax bill.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,793 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Adult Day Care- 760 Square Feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	50,091	1990	$ 28,460	1
2					2
3	TOTALS	50,091		$ 28,460	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	250		1990	1975	$ 5,384,307	$	35	$ 153,837	$ 153,837	$ 3,217,759	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1980	5,655		20			5,655	9
10	Various			1981	13,906		20			13,906	10
11	Various			1982	1,171		20			1,171	11
12	Various			1983	17,000		20			16,819	12
13	Various			1984	36,737		20			36,737	13
14	Various			1985	135,882		20			135,840	14
15	Various			1986	63,852		20			63,018	15
16	Various			1987	60,439		20			60,094	16
17	Various			1988	24,257		20			23,967	17
18	Various			1989	102,083		20	27	27	101,961	18
19	Various			1990	84,998		20	1,291	1,291	84,994	19
20	Various			1991	10,496		20	525	525	10,400	20
21	Various			1992	18,109		20	890	890	16,606	21
22	Various			1993	39,981		20	1,999	1,999	35,332	22
23	Various			1994	123,996		20	6,200	6,200	102,827	23
24	Various			1995	157,007		20	7,850	7,850	123,822	24
25	Various			1996	210,423		20	10,521	10,521	151,331	25
26	Various			1997	97,938		20	4,897	4,897	66,564	26
27	Various			1998	76,538		20	3,827	3,827	46,925	27
28	Various			1999	232,757		20	11,331	11,331	128,978	28
29	Various			2000	88,771		20	4,409	4,409	47,090	29
30	Various			2001	147,900		20	7,704	7,704	73,203	30
31	Various			2002	156,983		20	9,839	9,839	127,552	31
32	Various			2003	478,211		20	42,642	42,642	362,321	32
33	Various			2004	276,659		20	28,721	28,721	191,157	33
34	Various			2005	89,345		20	8,680	8,680	52,512	34
35	Various			2006	90,306		20	6,521	6,521	29,762	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			321,029			(321,029)		69
70	TOTAL (lines 4 thru 69)		$ 8,225,707	$ 321,029		$ 311,710	$ (9,319)	$ 5,328,304	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 8,225,707	$ 321,029		$ 311,710	$ (9,319)	$ 5,328,304	1
2	Crash Rail	2007	3,396		20	227	227	793	2
3	Exhaust Fan	2007	2,982		20	199	199	696	3
4	Water Tank	2007	9,977		20	665	665	2,329	4
5	Wiring	2007	1,552		20	104	104	362	5
6	North Town Water Tank	2007	6,000		20	400	400	1,400	6
7	Doors	2007	1,175		20	59	59	211	7
8	Electric Work	2007	14,962		20	998	998	3,492	8
9	Carpeting	2007	4,500		20	643	643	2,250	9
10	Improvements	2007	35,896		20	2,394	2,394	8,378	10
11	Perf Plumbing	2007	2,856		20	191	191	667	11
12	Plumbing	2007	3,107		20	207	207	725	12
13	Plumbing	2007	2,729		20	182	182	637	13
14	Walk-In Freezer & Cooler Repair	2007	3,753		20	375	375	1,220	14
15	Replace 2Nd Main Pump	2007	5,455		20	546	546	2,182	15
16	Plumbing Repair	2007	2,876		20	288	288	1,007	16
17	Hvac Repair	2007	2,617		20	262	262	960	17
18	Window Treatments	2007	8,355		20	418	418	1,427	18
19	Drapes	2007	3,607		20	180	180	646	19
20	Hucker Electric	2008	1,909		20	191	191	557	20
21	Boiler/Water Heater - Northtown	2008	17,600		20	1,467	1,467	4,278	21
22	Northtown Mechanical - Piping	2008	4,820		20	482	482	1,366	22
23	Braille Signs	2008	579		20	116	116	338	23
24	Wood Blinds	2008	1,452		20	145	145	399	24
25	Braile Sign	2008	669		20	134	134	368	25
26	Rich Signs	2008	679		20	136	136	374	26
27	Wood Blinds	2008	1,418		20	142	142	378	27
28	Braile Sign	2008	736		20	147	147	392	28
29	Lights	2008	3,196		20	639	639	1,758	29
30	Wall Sconce	2008	525		20	105	105	276	30
31	Sheridan Road Sign Lighting	2008	3,914		20	783	783	2,055	31
32	Smoke Tower Receptacle And Street Lighting	2008	4,450		20	445	445	1,150	32
33	Receptacles	2008	1,393		20	139	139	360	33
34	TOTAL (lines 1 thru 33)		$ 8,384,843	$ 321,029		$ 325,117	$ 4,088	$ 5,371,733	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 8,384,843	$ 321,029		$ 325,117	$ 4,088	$ 5,371,733	1
2	North Town Mechanical	2008	4,010		20	802	802	1,938	2
3	North Town Mechanical	2008	4,046		20	809	809	1,956	3
4	Senior Technologies - Wanderguard	2008	4,987		20	997	997	2,327	4
5	North Town - Replace 100 Ton Comp	2008	21,589		20	2,159	2,159	4,588	5
6	Freezer Compressor	2008	3,100		20	310	310	659	6
7	Freezer Refrigeration	2008	7,827		20	783	783	1,663	7
8	Material - Northtown	2008	2,704		20	541	541	1,172	8
9	Universal Elevator Works	2008	6,475		20	648	648	1,403	9
10	2 Elevators	2008	3,500		20	350	350	729	10
11	Wanderguard	2008	3,880		20	776	776	1,617	11
12	North Town - Boiler	2008	3,872		20	387	387	807	12
13	Replace Freezer Refrigeration	2008	7,826		20	783	783	1,630	13
14	Repair Leak, Replace Main & Circulating Pumps	2009	4,387		20	439	439	877	14
15	Boiler Room Pump Repair	2009	6,306		20	526	526	1,051	15
16	Overhead Line On Elevator Hoistway	2009	6,475		20	648	648	1,241	16
17	Tile & Coving Installation In Foyer Area	2009	3,396		20	340	340	623	17
18	Replace T-Couple On Cleaver Brook Boiler	2009	2,883		20	288	288	529	18
19	Replace Domestic Water Piping	2009	4,261		20	426	426	781	19
20	North Town Mechanical	2009	32,686		20	3,269	3,269	5,720	20
21	Hot Water Line	2009	2,511		20	251	251	398	21
22	Water Pipes	2009	4,260		20	426	426	781	22
23	Water Pipes	2009	4,080		20	408	408	646	23
24	Exterior Brick Work	2009	36,000		20	3,600	3,600	5,100	24
25	Roof Repairs	2009	4,960		20	496	496	703	25
26	Doors, Ramp, & Decking	2009	20,165		20	2,017	2,017	2,689	26
27	Windows	2009	8,909		20	891	891	1,039	27
28	Roof Drains	2009	14,156		20	1,416	1,416	1,652	28
29	Ahu Bearings	2009	2,546		20	255	255	276	29
30	Cooling Tank	2009	4,355		20	436	436	472	30
31	Jockey Pump	2009	2,601		20	260	260	282	31
32	Bearing Assembly	2009	3,043		20	304	304	355	32
33	Boiler Maintenance	2009	4,008		20	401	401	468	33
34	TOTAL (lines 1 thru 33)		$ 8,630,646	$ 321,029		$ 351,554	$ 30,526	$ 5,417,902	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 8,630,646	$ 321,029		$ 351,554	$ 30,526	$ 5,417,902	1
2	Electrical Circuit Work	2009	6,750		20	675	675	788	2
3	Painting	2009	3,720		20	372	372	682	3
4	Painting	2009	3,720		20	372	372	651	4
5	2Nd Floor Flooring	2010	43,195		20	3,960	3,960	3,960	5
6	Handrails	2010	24,153		20	2,013	2,013	2,013	6
7	Elevator Motor	2010	6,030		20	603	603	603	7
8	Window Installation	2010	31,620		20	2,372	2,372	2,372	8
9	New Circuits	2010	7,110		20	260	260	260	9
10	Roofing	2010	7,775		20	648	648	648	10
11	Security System	2010	9,739		20	730	730	730	11
12	Wallcoverings	2010	6,597		20	550	550	550	12
13	Laminate Countertop	2010	3,658		20	366	366	366	13
14	Dining Room Buildout	2010	5,974		20	548	548	548	14
15	Concrete Steps & Rail	2010	4,400		20	296	296	296	15
16	Wall Coverings	2010	2,844		20	190	190	190	16
17	Wallcoverings	2010	4,211		20	246	246	246	17
18	Handrails-3Rd Floor	2010	31,195		20	1,560	1,560	1,560	18
19	Refrigeration Fan	2010	2,990		20	150	150	150	19
20	Air Conditioner Compressor	2010	5,429		20	226	226	226	20
21	Volt 30 Amp Circuit	2010	3,313		20	138	138	138	21
22	Insulation	2010	36,145		20	904	904	904	22
23	Fire Dampers	2010	3,587		20	60	60	60	23
24	Privacy Curtains	2010	11,063		20	1,291	1,291	1,291	24
25	Roller Shades	2010	9,752		20	975	975	975	25
26	3 Fire Dampers	2010	3,587		20	60	60	60	26
27	Exhaust Fan	2010	6,674		20	56	56	56	27
28	Wallcoverings	2010	6,597		20	385	385	385	28
29	Glass	2010	2,971		20	74	74	74	29
30	Wiring	2010	6,037		20	101	101	101	30
31	Pump And Piping	2010	13,527		20	1,353	1,353	1,353	31
32	New Windows And Doors	2010	7,200		20				32
33	New Windows	2010	56,746		20				33
34	TOTAL (lines 1 thru 33)		$ 9,008,955	$ 321,029		$ 373,083	$ 52,054	$ 5,440,132	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 9,008,955	$ 321,029		$ 373,083	$ 52,054	$ 5,440,132	1
2	Flooring	2010	60,516		20				2
3	Penthouse Air Handler & Laundry Rm Exhaust Fan Maintenance	2010	4,272		20				3
4	Electrical Maintenance:Panels,Receptacles,Generator	2010	3,065		20				4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,076,807	$ 321,029		$ 373,083	$ 52,054	$ 5,440,132	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$	$		$	$	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$	$		$	$	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 928,986	$	$ 86,804	$ 86,804	10	$ 760,018	71
72	Current Year Purchases	241,479		20,724	20,724	10	20,724	72
73	Fully Depreciated Assets	860,151				10	860,151	73
74								74
75	TOTALS	$ 2,030,616	$	$ 107,528	$ 107,528		$ 1,640,893	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	VAN	2008	$ 15,461	$	$ 2,324	$ 2,324	5	$ 6,939	76
77										77
78										78
79										79
80	TOTALS			$ 15,461	$	$ 2,324	$ 2,324		$ 6,939	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,151,344	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 321,029	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 482,936	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 161,907	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,087,964	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	LAND - 1994	$ 199,000	$	$	86
87	REMODEL STORAGE ROOM - 1999	4,000		4,000	87
88	REMODEL STORAGE RM - 1999	10,000	500	7,417	88
89	REMODEL STORAGE ROOM - 1999	4,300	215	3,165	89
90	DAYCARE CTR ARCHITEC - 2000	787	15	221	90
91	TOTALS	$ 218,087	$ 730	$ 14,803	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 13,137 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrator	2008 Acura RL	$ 831.53	$ 9,147	17
18					18
19					19
20					20
21	TOTAL		$ 831.53	$ 9,147	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 219,346	$		$ 219,346	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			42,871			42,871	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			247,181			247,181	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				293,322		293,322	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					64,242	304,931		369,173	13
14	TOTAL			$		$ 573,640	$ 598,253		$ 1,171,893	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 342,346	$	1
2	Cash-Patient Deposits	84,483		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	957,075		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	2,000		5
6	Prepaid Insurance	126,292		6
7	Other Prepaid Expenses	58,724		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	82,681		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,653,601	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	227,460		13
14	Buildings, at Historical Cost	5,384,307		14
15	Leasehold Improvements, at Historical Cost	3,479,970		15
16	Equipment, at Historical Cost	2,191,470		16
17	Accumulated Depreciation (book methods)	(6,710,644)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	35,170		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,607,733	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,261,334	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 863,355	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	90,470		28
29	Short-Term Notes Payable	921,973		29
30	Accrued Salaries Payable	242,878		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	224,482		32
33	Accrued Interest Payable	13,530		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,356,688	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	50,349		39
40	Mortgage Payable	2,088,967		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,139,316	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,496,004	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,765,330	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,261,334	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,584,874	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,584,873	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	180,457	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 180,457	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,765,330	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,794,483	1
2	Discounts and Allowances for all Levels	240,537	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,035,020	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	785,873	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 785,873	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	222,503	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,965	19
20	Radiology and X-Ray		20
21	Other Medical Services	42,355	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 290,823	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,906	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,906	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	6,152	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,152	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,119,774	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,638,916	31
32	Health Care	4,942,163	32
33	General Administration	2,200,687	33
	B. Capital Expense		
34	Ownership	778,829	34
	C. Ancillary Expense		
35	Special Cost Centers	1,247,367	35
36	Provider Participation Fee	131,355	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,939,317	40
41	**Income before Income Taxes (line 30 minus line 40)****	180,457	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 180,457	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,866	1,866	$ 80,350	$ 43.06	1
2	Assistant Director of Nursing	2,403	2,403	71,377	29.70	2
3	Registered Nurses	17,105	19,477	642,852	33.01	3
4	Licensed Practical Nurses	36,027	41,684	1,217,261	29.20	4
5	CNAs & Orderlies	124,356	136,128	1,693,904	12.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	16,828	19,079	197,123	10.33	8
9	Activity Director					9
10	Activity Assistants	16,708	18,746	195,222	10.41	10
11	Social Service Workers	14,402	10,349	214,117	20.69	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	44,931	49,733	575,525	11.57	15
16	Dishwashers					16
17	Maintenance Workers	17,918	20,374	244,966	12.02	17
18	Housekeepers	32,834	36,317	415,060	11.43	18
19	Laundry	12,577	13,585	154,841	11.40	19
20	Administrator	2,138	2,409	118,674	49.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,577	13,487	228,962	16.98	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,563	7,641	135,340	17.71	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,080	2,080	58,577	28.16	33
34	TOTAL (lines 1 - 33)	361,313	395,358	$ 6,244,151 *	$ 15.79	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 16,828	01-03	35
36	Medical Director	Monthly	31,050	09-03	36
37	Medical Records Consultant	Monthly	6,108	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	12,408	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	6,773	11-03	44
45	Social Service Consultant	Monthly	8,728	12-03	45
46	Other(specify) Art Therapy Cons.	Monthly	40,074	11-03	46
47	Rehab Consultant	Monthly	14,107	10a-03	47
48	Special Services/Psychiatric Cons.	Monthly	3,199	10-03	48
49	TOTAL (lines 35 - 48)		$ 139,275		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,416	$ 85,398	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,416	$ 85,398		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Julia Stangel	Administrator	0	$ 118,674
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 118,674

B. Administrative - Other

Description	Amount
Management Fees- Pro Health Care	$ 56,000
Payments to Previous Administrator	8,542
TOTAL (agree to Schedule V, line 17, col. 3)	$ 64,542
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 32,326
Steven Elster	Computer Services	500
Property Valuation Services	Real Estate Appraisal	3,500
Paychex	Payroll Processing	18,097
Personnel Planners	Unemployment Tax Cons.	3,610
See Attached	Legal Fees	25,451
Credit Collections	Adj Pg 5a	1,729
Chicago Title Land Trust	Refinance (adj pg 5a)	175
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 85,388

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 142,485
Unemployment Compensation Insurance	63,513
FICA Taxes	467,560
Employee Health Insurance	370,476
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Personnel Costs	39,736
Other Employee Benefits	7,073
Christmas Expense	16,452
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,107,295

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	21,888
Health Care Worker Background Check	800
(Indicate # of checks performed 80)	
Patient Background Checks	
IL Council On LTC	20,765
Dues & Subscriptions	3,655
Licenses & Fees	2,825
Less: Public Relations Expense	(8,833)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 43,090

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	14,380
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,380

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/10 Ending: 12/31/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ILCLTC- $20,765**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **Yes** If YES, what is the capacity? **230**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **61,902** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **131,355**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Line 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.